MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE
Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room, Atlanta, GA 30303

Friday, May 13, 2005
1:00 pm - 3:00 pm

Harve R. Bauguess, Chair, Presiding

MEMBERS PRESENT

Pamela Cartwright
James Coughenour
Hazel Dorsey
Ron Hunt
John Lindsey
Julia L. Mikell, M.D. (via conference call)
Dennis Skelley, FACHE
Diane Waldner
Wylene Watts
Carol Zafiratos

MEMBERS ABSENT

Donald Avery, FACHE
Leanne Dennis
Patricia Fraley
Brad Griffin
Edwinlyn Heyward
Kathy Kleinsteuber
Jan Marie Popovich
Mary Sloan, MPA

GUESTS PRESENT

Jennifer Bach, Mitretek Healthcare Gill/Balsano
Brian Crevesse, Parker Hudson Rainer & Dobbs
Annemarie Fitzgerald, Atlanta Medical Center
Mark Mullin, Gwinnett Health System
Nathan Nesmith, South Fulton Medical Center
Helen Sloat, Nelson Mullins
Daniel Sullivan, Sullivan Consulting
Leah Fressell Watkins, Powell Goldstein

STAFF PRESENT

Charemon Grant, JD
Richard Greene, JD
Matthew Jarrard, MPA
Robert Rozier, JD
Virginia Seery, PhD
Geeta Singh, MHA
Stephanie Taylor

WELCOME

The Inpatient Physical Rehabilitation Services Technical Advisory Committee (TAC) meeting commenced at 1:05 pm. Harve Bauguess, Chair, welcomed members and guests and invited guests to introduce themselves. Mr. Bauguess noted the following committee member replacements: Hazel Dorsey, RN, Utilization and Quality Manager, State Health Benefits Plan, replaced Cheryl Williams (same Department). Ron Hunt, MD, Medical Director, Blue Cross Blue Shield of Georgia replaced Charles Harmon, same organization.

Following his introductory remarks, Mr. Bauguess called for a motion to approve the minutes of the meeting of April 15, 2005. Mr. Skelley made note of the following typographical error on page 6 of the draft minutes: The word "their" should be changed to "there". Following acceptance of this change, a motion to accept the minutes was made by Mr. Skelley, seconded by Pamela Cartwright. TAC members unanimously approved the minutes, pending correction.

REVIEW AND AFFIRM STANDARDS REACHED VIA COMMITTEE CONSENSUS

Mr. Bauguess called upon Stephanie Taylor to review the standards that the committee had discussed at earlier meetings and to seek affirmation of those standards. Ms. Taylor stated that the acceptance of these standards would require committee vote. The vote would be a conceptual agreement of the standards, not a vote to approve any proposed language.

APPLICABILITY

Ms. Taylor indicated that this standard would indicate that providers seeking to offer new or expanded inpatient physical rehabilitation services for children, adults and patients with spinal cord and traumatic brain injuries, including life long living programs and transitional living programs, would be included under the Applicability Standard.

Mr. Skelley made a motion, seconded by Wylene Watts to include this standard in the draft proposed Rules.

DEFINITIONS

Ms. Taylor reviewed the following standards:

- *New" – means the provider has never offered the service in the past*
- *"Expanded" – means an existing facility would be able to increase the number of inpatient rehab beds, every 2 years, providing some occupancy level has been reached.*

Committee members said that the term "expanded" should be defined as an increase in the number of beds. Issues regarding the frequency of the expansion and occupancy levels should be further explored during the discussion of the need methodology.

- *"Adult"- means persons 18 years of age and older but no younger than 16 years of age. Note: Emancipated minor- means that parental control has been legally terminated. These individuals would be recognized as adults in Georgia.*
- *"Child" means persons 0-17 years of age but no older than 21 years of age.*

Note: Language would be included that a provider would not be in violation of this Rule if, based on medical necessity and patient choice, service was provided to patients in overlapping age groups.

Mr. Greene asked whether age is the appropriate criterion to use when trying to decipher between an "adult" and a "child". Dr. Hunt indicated that any definition for "adult" or "child" would rely upon age.

Other committee members indicated that:

- There should be consideration of the clinical issues of dealing with someone in developmental stages below seventeen years of age and those above that age threshold;.
- There are liability insurance issues associated with treating patients 17 years of age and younger.

TAC members unanimously approved the conceptual definitions of "adult" and "child" as proposed.

QUALITY STANDARDS: CARF ACCREDITATION/ DHR LICENSURE REQUIREMENTS

Ms. Taylor reviewed the following standards:

- *New providers must meet the intent of the CARF standards, within 36 months.*
- *Providers seeking to expand services must be accredited (by CARF?) prior to receiving CON approval*
- *Spinal Cord Injury Programs – there are no licensure requirements for these programs. Language contained in the current Rules should be removed for spinal cord injury programs only.*

Members were provided with a list of CARF-accredited facilities which was requested at last month's meeting.

Ms. Zafiratos asked for clarification of the phrase "meeting the intent of the CARF standards". Mr. Rozier clarified that a new service could not have met CARF standards. Applicants seeking to offer **new** services would state in their CON applications that they intend to meet the CARF standards and intend to apply for CARF accreditation within three years of CON approval. Those applicants seeking to **expand** their facilities would be required to have achieved CARF accreditation.

Members expressed concern about the lack of an enforcement mechanism to ensure that standards are adhered to and accreditation is actually obtained. They noted that if within

three years the facility has not become CARF accredited, there is no penalty imposed upon the facility.

The committee discussed the high costs associated with CARF accreditation. They noted that it might be a financial burden on small and rural facilities.

Committee members unanimously agreed that providers seeking to expand services must be accredited by CARF.

Mr. Skelley confirmed the committee's recommendation noting that there should no longer be a separate category for beds for spinal cord injury patients. He indicated that those beds would be rolled into the total inventory.

Ms. Taylor reminded committee members that there are no licensure requirements for spinal cord injury programs. The committee voted unanimously to accept the quality standards for CARF Accreditation/DHR licensure requirements.

QUALITY STANDARDS: REFERRAL ARRANGEMENTS

An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document the existence of referral arrangements with an acute-care hospital(s) to provide acute and emergency medical treatment to any patient who requires such care.

Ms. Taylor confirmed that this standard applies to freestanding facilities only. TAC members unanimously agreed to the inclusion of this standard for freestanding facilities.

ADVERSE IMPACT

Mr. Rozier noted that most of the Department's Rules contain adverse impact standards, including General Short Stay Hospital Beds, Open-Heart Surgical Services, Perinatal Health Services, Radiation Therapy, and Cardiac Catheterization Services Rules. He said that the current Inpatient Physical Rehab Rules do not contain adequate adverse impact standards and appears below:

An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program for Spinal Cord Disorders shall document the impact on existing and approved services in the planning area with the goal of minimizing adverse impact on the delivery system

He briefly reviewed the adverse impact standards contained in other Department Rules:

<u>General Short Stay Hospital Bed</u>

- Standards organized by three different areas:
  - Teaching Hospitals

- Safety Net Hospitals
- Other Facilities

- Adverse impact is defined as projected annual utilization decreases of 10% for safety net hospitals and 5% for teaching hospitals.

Open Heart Surgery

Impact on an existing or approved service shall be determined to be adverse if, based on the number of cases projected to be performed by the applicant, any of the existing or approved services would have either a decrease in volume equal to or greater than 10% of the average annual service volume in the preceding two calendar years or a decrease of less than 10% of the annual service volume in the proceeding two calendar years but which would result in such service falling below a minimum of 200 open heart surgical procedures annually.

Perinatal Services

- Includes standards for physician training programs, midwifery training programs, and regional perinatal centers.
- Does not include any standard containing percentages or any numerical measures of adverse impact.

Radiation Therapy

- The applicant's new or expanded service cannot cause an existing service to fall below 80% of optimal utilization.
- For those existing services who are already under 80% optimal utilization, the application should document that it will not cause this existing service to fall more than 10% below its current utilization.

Mr. Rozier reiterated that the burden is placed on the applicant to prove that no adverse impact will be created as a result of the new or expanded service. He suggested that the committee could select one of the existing adverse impact standards from any of the Department's service-specific rules or members could recommend some other measure of adverse impact. He further said that adverse impact standards work well when they are specific and detailed.

Mr. Skelley stated that he would be in favor of developing language for adverse impact similar to the standard contained in the General Short-Stay Hospital bed Rules.

Mr. Rozier asked if there are different types of rehab facilities or categories of rehab beds that would require different adverse impact considerations. Mr. Skelley suggested that the same principle of adverse impact would apply to all categories of rehab beds including TBI & spinal cord beds. Ms. Watts added that adverse impact should consider both the overall impact to the institution and to specific unit areas.

Committee members inquired about the reasoning behind the 10% and the 5% adverse impact measurements that are contained in the Rules for General Short Stay Hospital Beds and the 10% in the Cardiovascular Services Rules.

Ms. Taylor indicated that the Specialized Cardiovascular Services TAC considered the relationships between volume and quality when examining the adverse impact statements. She said that it was that TAC's contention that the number of patients that existing providers would be required to see should not be decreased beyond a certain point where the provider's level of proficiency in the service area would decline. (These volume guidelines were established by American College of Cardiology and American Heart Association). She further noted that teaching hospitals are required to maintain certain volume standards in order to maintain their funding sources and to ensure provider proficiencies for training programs. She said that the Short Stay General Hospital TAC felt that the state's safety net providers and teaching hospitals should be preserved given their training and indigent and charity care missions and given the significant financial investment made by the state.

Mr. Skelley said that there are three types of rehabilitation providers which range in size order, from large to small, as follows: freestanding rehab hospitals, hospital-based units, and TBI facilities. He suggested that facility size may provide the committee with some guidance about how specific adverse impact statements could be crafted.

The committee conceptually agreed that an adverse impact statement similar to that contained in the General Short Stay Hospital Rules should be included in the Rules.

QUALITY STANDARDS: UTILIZATION REVIEW

Ms. Taylor reviewed the current utilization review standard and asked whether the current standard is sufficient or whether it needs to be refined:

> *An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have written policies and procedures for utilization review. Such review shall include, but is not limited to, factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization.*

Mr. Rozier added that at present applicants meet the intent of this standard by submitting their utilization review polices to the Department.

Dr. Hunt made a motion, seconded by Wylene Watts, to maintain this utilization review standard. Committee members approved the motion unanimously.

DEFINITIONS AND PROGRAM GUIDELINES

Ms. Taylor reviewed the Definitions and Program Guidelines Standard (Appendix B of current State Health Plan) as follows:

> *An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document the intent to comply with the Physical Rehabilitation Services and Programs: Definitions and Program Guidelines, as described in the most recent official State Health Component Plan for Physical Rehabilitation Programs and Services.*

Ms. Taylor asked the Committee whether Appendix B needs to be updated or eliminated. Mr. Skelley, who served on the previous Rehab TAC, said that the purpose of the document was to educate TAC members of the different levels of care. He said that during the early 1990's this tool was very useful.

Committee members indicated that if the Appendix provides value to the Department in the review of the application, that it should be updated. Mr. Rozier suggested that the Department would identify the areas of the Appendix that would be most useful and would update those areas so that it could be more relevant and useful in the CON review process.

ACCESS

Ms. Taylor reviewed current access standards:

A. FINANCIAL

An applicant for a new or expanded Comprehensive Inpatient Rehabilitation Program for Spinal Cord Disorders shall foster an environment, which assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

(i) providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis:

(ii) providing a written commitment that unreimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustment and bad debt have been deducted; and

(iii) providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of unreimbursed indigent and charity care.

ICC and written policies

There was some committee discussion of the provision of a 3% indigent and charity care commitment. Staff clarified that the committee can recommend a higher or lower commitment level. If the recommended amount were lower than the standard (3%), the committee would have to justify the recommendation.

Members also discussed the provision of a facility-wide commitment versus a service-specific commitment. Members noted that if another part of the facility shares the burden of providing care, for other services, that this does not ensure access to care for rehabilitation patients. Members said that the committee's objective is to ensure access to rehab services.

Members said that in the best interest of the citizens of Georgia, that the committee should maintain the current 3% indigent charity care service-specific commitment. The committee unanimously approved the standard, along with the standard to provide written administrative policies.

Medicare/Medicaid Participation

Mr. Rozier explained that when the Department is reviewing CON applications, it examines providers' history of providing indigent and charity care and its Medicaid/Medicare participation to see if it is comparable to other facilities in the region. If the applying facility's history is not comparable to other facilities in the region, this provides a potential reason to deny the CON application.

Ms. Watts made the motion, seconded by Dr. Hunt, to keep the current standard for Medicare/Medicaid participation and indigent/charity requirements. The committee unanimously approved this motion.

B. GEOGRAPHIC ACCESS

Mr. Rozier reviewed the geographic access standard as follows:

> *A new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be developed in a manner that improves the distribution of beds for similar programs, existing or approved, within the State, based on geographic and demographic characteristics.*

He noted that this standard provides little specificity.

Mr. Coughenour made a motion, seconded by Ms. Watts, to maintain this standard. This motion was approved unanimously be the committee.

COST

Mr. Rozier discussed standards for patient charges:

An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program for Spinal Cord Disorders shall demonstrate that charges for services compare favorably with charges for similar services in the State, when adjusted for inflation.

Mr. Rozier explained that one long-standing concern about this standard is that many applicants have indicated that they have difficulty meeting the burden of this rule because there is no mechanism to obtain charge data of other providers.

There was some committee discussion of the term "charges". Dr. Hunt noted that "charges" is only relevant when there is discussion of the uninsured.

The committee agreed that the main objective of keeping this standard would be to ensure that the applicant is being fair to uninsured clients and not charging them an unreasonable amount for services. They agreed that language needs to be modified so that the applicant can demonstrate this with relative ease.

Committee members suggested that the applicant should address the issue of "charges" for the uninsured more specifically in the financial access and discrimination policies they submit to the Department. The committee unanimously approved the inclusion of this standard.

DATA & INFORMATION

Mr. Rozier reviewed the following data and information standards:

An applicant for a new or expanded Comprehensive Inpatient Rehabilitation Program shall agree to provide the State Health Planning Agency with requested information and statistical data related to the operation of such a Program on a yearly basis, or as needed, and in a format requested by the Agency.

The committee unanimously approved the inclusion of this standard.

PUBLIC COMMENTS

Mr. Bauguess asked if anyone was interested in making public comment. No one indicated the desire to speak.

OTHER BUSINESS

Mr. Greene asked the committee to look at rule 111-2-2-.05 (Appendix A). These Rules outline the enforcement authority of the Department. .

Ms. Taylor noted that at the next meeting, the committee would discuss the need methodology. She encouraged members to review the summary document which outlined all of the need methodologies from various states.

FUTURE MEETING

The next TAC meeting is scheduled for **Friday, June 17th, at 2 Peachtree Street, Atlanta, 34th Floor Conference Room from 1:00 pm-3:00 pm.**

Mr. Bauguess thanked all members for their participation in today's meeting. The meeting ended at 3:20 pm.

Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,

Harve Bauguess, Chair

APPENDIX A

Rule 111-2-2-.05: Enforcement

111-2-2-.05 Enforcement.

(1) Revocation.

(a) In the event that the Department has cause to consider revocation of a Certificate, the Department shall provide notice to the holder of the Certificate and shall hold a hearing to determine whether the holder has:

1. Intentionally provided false information to the Department;

2. Failed to incur a financial obligation in accordance with the Certificate as granted;

3. Failed to implement the project in accordance with the specific purpose(s) for which the certificate was granted or failed to meet the initial twelve-month performance standards or failed to request an extension of such standards;

4. Transferred controlling ownership in the facility before completion of the project without prior written approval of the Department, except as authorized by 111-2-2-.02(4);

5. Changed the defined location of the project except as allowed by O.C.G.A. § 31-6-45(a) authorizing change in location under certain conditions;

6. Failed to comply with any and all requirements or conditions of the Certificate; or

7. Failed to submit complete and accurate periodic reports as required by 111-2-2-.04.

(b) In the event that there is sufficient evidence to justify revocation of a Certificate, the Department shall provide written notification to the holder, which shall be effective as of the postmark date on the notification letter. Notice shall also be provided to the public, to the county or municipal authority and to the appropriate Regional Development Center. Any person whose Certificate is revoked under this rule is entitled to judicial review, pursuant to O.C.G.A. § 50-13 et seq.

(c) A person whose Certificate of Need has been revoked or denied may not reapply for a Certificate of Need for the same or substantially similar project for at least one hundred twenty (120) days from the date that the revocation or denial becomes final, at which time the person may submit a new application. For purposes of this subparagraph, a decision revoking or denying a Certificate of Need shall become final when the time for appealing that decision expires without an appeal of such decision having been timely filed. If an appeal is timely filed, the decision is not final until the resolution of the administrative appeal, if any.

(d) A person holding a Certificate of Need may voluntarily request revocation of the Certificate without prejudice by submitting such request to the Department in writing.

(e) A health care facility which has a certificate of need or is otherwise authorized to operate pursuant to this chapter shall have such certificates of need or authority to operate automatically revoked by operation of law without any action by the Department when that

facility's permit to operate pursuant to O.C.G.A. § 31-7-4 is finally revoked by order of the Department of Human Resources. For purposes of this subsection, the date of such final revocation shall be as follows:

1. When there is no appeal of the order pursuant to O.C.G.A. § 31-5, the one hundred and eightieth day after the date upon which expires the time for appealing the revocation order without such an appeal being filed; or

2. When there is an appeal of the order pursuant to O.C.G.A. § 31-5, the date upon which expires the time to appeal the last administrative or judicial order affirming or approving the revocation or revocation order without such appeal being filed.

The Department may become a party to any judicial proceeding to review a decision by the Department of Human Resources to revoke such a permit.

(f) A certificate shall be subject to revocation for the following failures, without limitation:

1. Failure to incur a project-specific capital expenditure, within the initial 12-month implementation period specified at 111-2-2-.02(6) and in the Certificate itself or within an extension implementation period granted by the Department, through initiation of substantial project above-ground construction or lease or purchase of the proposed equipment;

2. Failure to file the required Progress Report(s);

3. Failure to meet the conditions on the face of the Certificate; or

4. Failure to pay any penalty assessed pursuant to O.C.G.A. § 31-6-40.1.

(2) **Sanctions.**

(a) Any health care facility offering a new institutional health service without having obtained a Certificate of Need and which has not been previously licensed as a health care facility shall be denied a license to operate by the Department of Human Resources.

(b) In the event that a new institutional health service is knowingly offered or developed without having obtained a Certificate of Need as required by O.C.G.A. § 31-6or by these Rules, or the Certificate of Need for such service is revoked according to the provisions of 111-2-2-.05(1), a facility or person may be fined an amount not to exceed $5,000.00 per day for every day that the violation of this these Rules and O.C.G.A. § 31-6 has existed and knowingly and willingly continues; provided however, that the expenditure or commitment of or incurring an obligation for the expenditure of funds to take or perform actions not subject to this chapter or to acquire, develop or prepare a health care facility site for which a Certificate of Need application is denied, shall not be a violation of this Chapter and shall not be subject to such a fine. The Commissioner or his designee shall determine, after notice and a hearing if requested, whether the fines provided in the Code section shall be levied.

(c) Any person who acquires a health care facility by stock or asset purchase, merger, consolidation, or other lawful means shall notify the Department of such acquisition, the date thereof, and the names and address of the acquiring person. Such notification shall be made

in writing to the Commissioner or his designee within 45 days following the acquisition and the acquiring person may be fined by the Department in the amount of $500.00 for each day that such notification is late.

(d) The Department may require that any applicant for a certificate of need commit to provide a specified amount of clinical health services to indigent or charity, Medicare, Medicaid, PeachCare, and similar patients as a condition for the grant of a Certificate of Need. A grantee or successor in interest of a Certificate of Need or authorization to operate under O.C.G.A. § 31-6 which violates such an agreement, whether made before or after July 1, 1991, shall be liable to the Department for a monetary penalty in the amount of the difference between the amount of services so agreed to be provided and the amount actually provided. Penalties authorized under this Code section shall be subject to the same notices and hearing for the levy of fines under 111-2-2-.05(2)(b).

(e) All hearings under this Section shall be in accordance with the "Georgia Administrative Procedure Act". Any person so penalized under this rule is entitled to judicial review, pursuant to O.C.G. A.§. 50-13 et seq.

(f) If the person assessed fails to pay the amount of the assessment to the Department within thirty (30) days after notice of assessment is postmarked to him, or within such longer period, not to exceed 90 days, as the Department may specify, the Department may institute a civil action to recover the amount of the assessment or may revoke the certificate of need. The Department may add reasonable interest to the assessment.

(g) For purposes of this Rule, the State of Georgia, acting by and through the Department or any other interested person, shall have standing in any court of competent jurisdiction to maintain an action for injunctive or other appropriate relief to enforce the provisions of this rule.

(3) **Department's Right to Inspect and Audit.** The Department or an authorized representative or employee designated by the Department shall have the right to inspect and audit any facility, site, location, book, document, paper, files, or other record of the holder of the certificate of need or letter of non-reviewability or other determination that is related to any project authorized by the certificate of need or letter of non-reviewability or other determination, in order to monitor and evaluate the person's compliance with the terms of issuance of the certificate of need or the letter of non-reviewability or other determination.